

# 5.1

## Examine the concepts of normality and abnormality

### Defining normality

Mental health model of normality (Jahoda, 1958)

The model suggests criteria for what might constitute normal psychological health (in contrast to abnormal psychological health). Deviation from these criteria would mean that the health of an individual is "abnormal":

- the absence of mental illness
- realistic self-perception and contact with reality
- a strong sense of identity and positive self-esteem
- autonomy and independence
- ability to maintain healthy interpersonal relationships (e. g. capacity to love)
- ability to cope with stressful situations
- capacity for personal growth and self-actualization.

Evaluation of the mental health model of normality

- The majority of people would be categorized as "abnormal" if the criteria were applied to them. It is relatively easy to establish criteria for what constitutes "physical health" but it is impossible to establish and agree on what constitutes "psychological health".
- According to Szasz (1962) psychological normality and abnormality are culturally defined concepts, which are not based on objective criteria.
- Taylor and Brown (1988) argue that the view that a psychologically healthy person is one that maintains close contact with reality is not in line with research findings. Generally people have "positive illusions" about themselves and they rate themselves more positively than others (Lewinsohn et al. 1980).
- The criteria in the model are culturally biased *value judgements*, i.e. they reflect an idealized rather than realistic perception of what it means to be human in a Western culture.

### Defining abnormality

The mental illness criterion (the medical model)

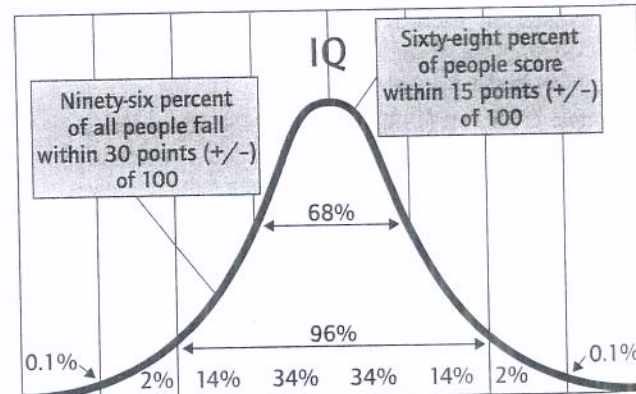
- The mental illness criterion sees psychological disorders (abnormality) as *psychopathology*. Pathology means "illness" so it is literally "illness in the psyche".
- This criterion is linked to psychiatry, which is a branch of medicine. Patients with psychological problems are seen as "ill" in the same way as those who suffer from physiological illnesses.
- Diagnosis of mental illness is based on the clinician's observations, the patient's self-reports, a clinical interview and diagnostic manuals (classification systems) that classify symptoms of specific disorders to help doctors find a correct diagnosis.

Evaluation of the mental illness criterion

- Proponents of the mental illness criterion argue that it is an advantage to be diagnosed as "sick" because it shows that people are not responsible for their acts.
- Although the origin of some mental disorders (e.g. Alzheimer's disease) can be linked to physiological changes in the brain, most psychological disorders cannot.
- Critics of the mental health illness criterion argue that there is a *stigma* (i.e. a mark of infamy or disgrace) associated with mental illness.
- Szasz (1962) argues that it is not possible to identify the biological correlates of mental illness. Therefore, psychological disorders should rather be seen as "problems of living".

Abnormality as statistical deviation from the norm

- Deviance in this criterion is related to the statistical average. The definition implies that statistically common behaviour can be classified as "normal". Behaviour that is deviant from the norm is consequently "abnormal". In the normal distribution curve most behaviour falls in the middle.
- An intelligence quotient of 150 deviates from the norm of 100. It is statistically rare but it is considered desirable to have high intelligence. Mental retardation is also rare but this is considered undesirable.
- Obesity is becoming increasingly statistically "normal" but obesity is considered to be undesirable.



Evaluation of the statistical criterion

- The use of statistical frequency and deviation from the statistical norm is not a reliable criterion to define abnormal behaviour since what is "abnormal" in a statistical sense may
- What may be considered abnormal behaviour can differ from one culture to another so it is impossible to establish universal standards for statistical abnormality. The model of statistical abnormality



### Abnormality as deviation from social norms

- Social norms constitute informal or formal rules of how individuals are expected to behave. Deviant behaviour is behaviour that is considered undesirable or anti-social by the majority of people in a given society. Individuals who break rules of conduct or do not behave like the majority are defined as "abnormal" according to this criterion.
- Social, cultural and historical factors may play a role in what is seen as 'normal' or 'abnormal' within a certain society. For example, homosexuality was seen as abnormal in Britain around 1900 where the famous writer Oscar Wilde was imprisoned for homosexuality. Homosexuality was classified as abnormal (sexual deviation) in the American Diagnostic and Statistical Manual DSM-II (1968). In later revisions of the manual homosexuality in itself was not seen as abnormal – only feeling distressed about it.

### Evaluation of the deviation from social norms criterion

- This criterion is not objective or stable since it is related to socially based definitions that change across time and culture. Because the norm is based on morals and attitudes, it is vulnerable to abuse. For example, political dissidents could be considered "abnormal" and sent to hospitals for treatment as occurred in the former Soviet Union.
- Using this criterion could lead to discrimination against minorities including people who suffer from psychological disorders.
- Psychological disorders may be defined and diagnosed in different ways across cultures and what seems to be a psychological disorder in one culture may not be seen in the same way in another culture. The American classification system DSM includes disorders called "culture-bound syndromes". This indicates that it is impossible to set universal standards for classifying a behaviour as abnormal.

## 5.2 Discuss validity and reliability of diagnosis

### Diagnosis

- Diagnosis within abnormal psychology means identifying and classifying abnormal behaviour on the basis of symptoms, the patients' self-reports, observations, clinical tests or other factors such as information from relatives.
- Clinicians use psychological assessment and diagnostic manuals to make diagnosis. The diagnostic manuals help to classify and standardize diagnosis.
- Diagnosis involves matching the results of the psychological assessment with classification systems such as DSM-IV-TR and ICD-10. The purpose of diagnosis is to find a treatment for the patient and to make a prognosis.

### Diagnostic manuals

- DSM-IV, now in its fourth revised version, is developed by the American Psychiatric Association. The manual lists what it terms "mental disorders". For each of the 300 disorders there is a list of symptoms that the clinician could look for in order to diagnose correctly. A new fifth version is on its way. The diagnostic manual does not identify causes of psychological disorders (etiology) but merely describes symptoms.
- ICD-10 (The International Classification of Diseases) is published by WHO (World Health Organization). The manual uses the term "mental disorder". The diagnostic manual includes reference to causes of the disorders (etiology).

### Reliability of diagnosis

- Reliability in diagnosis means that clinicians should be able to reach the same correct diagnosis consistently if they use the same diagnostic procedure (e.g. standardized clinical interview, observation of the patient's symptoms, neuropsychological examination with scanners and diagnostic manuals). This is called interjudge reliability.
- Reliability can be improved if clinicians use standardized clinical interview schedules, which define and specify sets of symptoms to look for. The individual psychiatrist must still make a subjective interpretation of the severity of the patient's symptoms.
- The introduction of diagnostic manuals has increased reliability of diagnosis over the year even though the manuals are not without flaws.

- Reliability of diagnosis is a necessary prerequisite for validity. Rosenhahn (1973) performed a classic study that challenged reliability and validity of psychiatric diagnosis and showed the consequences of being labelled as "insane". In this study eight pseudo-patients were diagnosed as suffering from severe psychological disorders but they were in reality imposters.

### Cooper et al. (1972) The US-UK Diagnostic Project

- The aim of the study was to investigate reliability of diagnosis of depression and schizophrenia.
- The researchers asked American and British psychiatrists to diagnose patients by watching a number of videotaped clinical interviews.





- The British psychiatrists diagnosed the patients in the interview to be clinically depressed twice as often. The American psychiatrists diagnosed the same patients to be suffering from schizophrenia twice as often.
- The results indicated that the same cases did not result in similar diagnosis in the two countries. This points towards problems of reliability as well as cultural differences in interpretation of symptoms and thus in diagnosis.

Fernando (1991) Diagnosis is a social process and it is not objective.

- Clinical assessment, classification and diagnosis can never be totally objective according to Fernando since there are *value judgements* involved. The diagnostic process in psychiatry is not the same as making a medical diagnosis. There may also be problems in understanding symptoms from individuals in different cultures.

### Validity of diagnosis

- Validity of diagnosis refers to receiving the correct diagnosis. This should result in the correct treatment and a prognosis (predictive validity). Validity presupposes reliability of diagnosis.
- It is much more difficult to provide a correct diagnosis and give a prognosis for a psychological disorder than for a physical disorder because it is not possible to observe objective signs of the disorder in the same way.
- The DSM-IV manual does not include etiology but only symptoms. Sometimes patients have symptoms that relate to different psychological disorders so it can be difficult to make a valid diagnosis.

Mitchel et al. (2009) Meta-analysis of validity of diagnosis of depression

- The study used data from 41 clinical trials (with 50,000 patients) that had used semi-structured interviews to assess depression.

- The general practitioners (GPs) had 80% reliability in identifying healthy individuals and 50% reliability in diagnosis of depression. Many GPs had problems making a correct diagnosis for depression.
- Generally GPs were more likely to identify false positive signs of depression after the first consultation. Mitchel et al. argued that GPs should see patients at least twice before making a diagnosis since accuracy of diagnosis was improved in studies that used several examinations over an extended period.
- **Evaluation of the study:** (1) The strengths of meta-analysis are that it can combine data from many studies and it is possible to generalize to a larger population; (2) Limitations of meta-analysis are that it may suffer from the problem of publication bias; since data from many different studies are used there may also be problems of interpretation of the data because it is not certain that each study uses exactly the same definitions.

Rosenhahn (1973) On being sane in insane places

**Aim** To test reliability and validity of diagnosis in a natural setting. Rosenhahn wanted to see if psychiatrists could distinguish between "abnormal" and "normal" behaviour.

**Procedure** This was a covert participant observation with eight participants consisting of five men and three women (including Rosenhahn himself). Their task was to follow the same instructions and present themselves in 12 psychiatric hospitals in the USA.

#### Results

- All participants were admitted to various psychiatric wards and all but one were diagnosed with schizophrenia. The last one was diagnosed with manic depression.
- All pseudo-patients behaved normally while they were hospitalized because they were told that they would only get out if the staff perceived them to be well enough.
- The pseudo-patients took notes when they were hospitalized but this was interpreted as a symptom of their illness by the staff. It took between 7 to 52 days before the participants were released. They came out with a diagnosis (schizophrenia in remission) so they were "labelled".

- A follow-up study was done later where the staff at a specific psychiatric hospital were told that impostors would present themselves at the hospital and that they should try to rate each patient whether he or she was an impostor. Of the 193 patients, 41 were clearly identified as impostors by at least one member of the staff, 23 were suspected to be impostors by one psychiatrist, and 19 were suspected by one psychiatrist and one staff member. There were no impostors.

#### Evaluation

- This controversial study was conducted nearly 40 years ago but it had an enormous impact in psychiatry. It sparked off a discussion and revision of diagnostic procedures as well as discussion of the consequences of diagnosis for patients. The development of diagnostic manuals has increased reliability and validity of diagnosis although the diagnostic tools are not without flaws.
- The method used raises ethical issues (the staff were not told about the research) but it was justified since the results provided evidence of problems in diagnosis which could benefit others. There were serious ethical issues in the follow-up study since the staff thought that impostors would present, but they were real patients and may not have had the treatment that they needed.

### Exam Tip

This study can be used as empirical research in unit 5.1 to examine concepts of normality and abnormality.



# 5.3

## Discuss cultural and ethical considerations in diagnosis

### Cultural considerations in diagnosis

Ballanger et al. (2001) suggest that variations in diagnosis across cultures do not necessarily reflect social or medical *reality*. There may be unknown factors influencing diagnosis, e.g. different methods of clinical assessment, differences in classification, lack of culturally appropriate instruments such as standardized clinical interviews, or problems in relation to translation of the clinical interviews. For these reasons, diagnosis is also linked to cultural variation in the prevalence of disorders.

Culture may influence psychiatric diagnosis in several ways.

1. Different cultural groups have different attitudes to psychological disorders that might influence the reporting of symptoms and diagnosis (e.g. due to stigmatization).
2. Cultural bias in diagnosis (i.e. the clinician does not observe certain symptoms because he or she is not familiar with the expression of distress in a particular culture).
3. Culture-bound syndromes (disorders that are specific to a particular culture) could be difficult to recognize for clinicians. This could prevent people from being treated.

### Emic or etic in diagnosis?

- The **universalist approach** (etic) to diagnosis emphasizes the cross-cultural equivalence of diagnostic concepts and underlying processes. Symptoms and disorders are manifestations of universal underlying processes.
- The **relativist approach** (emic) to diagnosis emphasizes a fundamental role of culture in psychopathology. Culture shapes symptoms and how people experience distress as well as their beliefs about causes and consequences of such problems.
- Clinicians could use universal clinical interviews and a classification system like the DSM-IV (i.e. taking an **etic** approach); or they could use culturally specific instruments that are developed to be used in a specific culture (i.e. taking an **emic** approach). In reality, most clinicians use the universal classification systems.
- Kirmayer (2001) argues that even though DSM-IV includes suggestions for a cultural interpretation of disorders, it still represents Western concepts of illness and therefore it may not be easily applied to other cultures.
- Bhui (1999) argues that diagnostic systems are necessary for comparisons between different cultures, and therefore it is necessary to define concepts of depression in accord with psychiatric and indigenous belief systems.

### Misdiagnosis due to cultural differences in expression of symptoms

- Jacobs et al. (1998) investigated a sample of Indian women in a general practice in London. The doctors were not likely to detect depression if the women did not disclose all their symptoms. The same has been found in research with cultural minorities in the USA and in Australia.
- People from traditional cultures may not distinguish between emotions and physical symptoms. For example, Chinese people have lower rates of depression and tend to deny depression or express it somatically (Zhang et al. 1998). In the 1980s, four fifths of psychiatric patients in China were diagnosed with "neurasthenia", a disorder that includes somatic, cognitive and emotional symptoms in addition to any depressive symptoms. This concept fits well with the traditional Chinese explanation of disease as a disharmony of vital organs and imbalance of "Qi" (the Chinese term for "life force" or "energy flow").
- Bhugra et al. (1997) carried out a focus group interview with Punjabi women in London. The women knew the term "depression" but the older ones used terms like "weight on my heart" or "pressure on the mind". They also talked about symptoms of "gas" and "heat". These terms are in accordance with traditional Indian medicine models of hot and cold.

### Case: culture and depression in China

- One of the most discussed cross-cultural differences in psychopathology was that depression was apparently very rare in China. Zhang et al. (1998) reported a survey in 12 regions in China in 1993 where only 16 out of 19,223 people said they had suffered from a mood disorder at some point in their life. This suggests a prevalence rate substantially lower than in the USA.
- According to Tseng and Hsu (1970) the Chinese are very concerned with the body and tend to manifest neurasthenic symptoms such as exhaustion, sleep problems, concentration difficulties, and other symptoms similar to the physical aspects of depression and anxiety.

### Neurasthenia – the Chinese version of depression?

- 'Neurasthenia' is a diagnosis that is not present in the DSM system. It is a Chinese diagnostic category signifying 'a weakness of nerves'.
- The diagnosis could be seen as a Chinese variation of depression characterized by bodily symptoms, fatigue and depressed feelings. This disorder is much more common in China than depression. One reason could be that this diagnosis is less stigmatizing in the Chinese culture.
- Another reason could be that the concept of neurasthenia fits better with the traditional way of explaining causes of disease in terms of disharmony of vital organs and imbalance of Qi. Diagnosis in traditional Chinese medicine means finding how Qi is blocked or imbalances of Qi.



### Kleinman (1982) Neurasthenia at a psychiatric hospital in China

- The aim of the study was to investigate if neurasthenia in China could be similar to depression in DSM-III.
- Kleinman interviewed 100 patients diagnosed with neurasthenia using structured interviews based on DSM-III diagnostic criteria.
- He found that 87% of the patients could be classified as suffering from depression; 90% complained of headaches, 78% of insomnia (sleep problems), 73% of dizziness, and 48% of various pains. Depressed mood was only given as the main complaint in 9% of the cases.
- Neurasthenia could be a specific Chinese way of expressing depression in somatic ways since the majority of the patients in the study only presented physical symptoms.
- It would be difficult to compare these data to Western data because patients do not make the same complaints during diagnosis. This shows one of the concerns in cross-cultural diagnosis. Somatization is perhaps the cultural mode of distress in China but in the West the most common mode of distress is *psychologization* (e.g. reference to mood).
- The implication of such findings are that Western clinicians should pay attention to somatization when they work with Chinese patients but they should at the same time be careful not to overdiagnose depression just because the patient complains of pain.

### Ethical considerations in diagnosis

- **Correct diagnosis and treatment:** Ethical consideration in diagnosis could refer to *reliability and validity of a diagnosis*. A reliable and valid diagnosis is the prerequisite for a *correct treatment* but unfortunately the diagnostic process is not without problems. Many disorders are not easy to identify correctly because they often occur together with symptoms of other disorders (the problem of comorbidity). For example, many patients with bulimia also suffer from depression.
- **Biases in diagnosis:** There may be various biases in the diagnostic process (e.g. gender bias, ethnicity bias or age bias) preventing a correct diagnosis. Clinicians may also be influenced by confirmation bias, i.e. having made a diagnosis they may not perceive information that contradicts it.
- **Considerations of normality and abnormality:** Ethical issues in diagnosis could also refer to *considerations of normality and abnormality* (see unit 5.1). It would be ethically wrong to diagnose a patient with a psychiatric disorder if the patient is not ill and in need of treatment. It would also be ethically wrong not to make a correct diagnosis if a patient needs treatment.
- **Stigmatization:** Rosenhahn (1975) claimed that a psychiatric diagnosis carries a personal, legal, and social *stigma*. He demonstrated that a diagnosis of a serious mental illness (schizophrenia) could be based on limited information. He also argued that a psychiatric diagnosis is often associated with significant consequences in terms of being considered "deviant" (social stigma).

### Jenkins-Hall and Sacco (1991) Ethnicity bias in diagnosis?

- The researchers presented videotapes of a person in therapy to a number of European American male and female therapists. The videos presented different situations (e.g. the patient was male or female, black or white, with depressed symptoms or non-depressed symptoms).
- The results showed that white therapists were more likely to make a false-positive diagnosis if the patient was black.

For example, a black patient would be diagnosed as depressed even in the absence of depressed symptoms.

### Broverman et al. (1970) Gender bias in diagnosis?

- **Rosser (1992)** argued that many psychiatrists are males whose perspective is situated within normative gender roles and a patriarchal culture. For example, if a woman is unhappy about her role as housewife and mother because she is stressed and bored, a male psychiatrist could diagnose her with depression. This would be an example of overdiagnosis.